STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING: _____ B. WING _____	11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILO MEDICAL CENTER	1190 WAIANUENUE AVENUE HILO, HI 96720

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4 000	Initial Comments A re-licensure survey was conducted by the Office of Health Care Assurance on November 3, 2021. The survey was conducted in conjunction with the recertification survey by the Healthcare Management Solutions, LLC on behalf of the Hawaii Department of Health, Office of Health Care Assurance on October 28, 2021. The facility was found not to meet the regulatory requirements for Hawaii Administrative Rules, Title 11, Chapter 94.1, Nursing Facilities.	4 000		
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: 1) Based on observations, record review, and staff interviews, the facility failed to ensure adequate interventions were provided to establish proper nutrition for one (Resident (R) 17) of three reviewed for nutrition in a total sample of 14 residents. The facility failed to re-weigh R17 per	4 136		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 136	Continued From page 1	4 136		

facility policy when a significant weight loss was first identified, failed to immediately assess R17's nutritional status after a significant weight loss, and failed to immediately notify R17's physician of the significant weight loss.

2) Based on record review and interviews, the facility failed to ensure timely treatment and services related to vision were provided for one (Resident (R) 20) of three reviewed for communication and sensory problems in a total sample of 14 residents.

3) Based on observations, interviews, and record review, the facility failed to ensure one resident (Resident (R) 23) of one, who was reviewed for positioning and mobility was provided with restorative services per her plan of care, in a total sample of 14 residents. R23 did not receive assistance to apply her splints per her plan of care. This failure had the potential to affect any resident who needed assistance implementing restorative care interventions.

Findings include:

1) Review of an undated document provided by the facility titled "Patient Registration Form," indicated R17 was admitted to the facility 03/23/21, with diagnoses that included hypertension (elevated blood pressure), left-sided weakness due to a cerebral vascular accident (CVA; stroke), and dementia.

Review of a care plan provided by the facility, dated 03/23/21 indicated R17 was nutritionally at risk. The care plan directed staff to encourage R17 to eat and drink, to monitor monthly and as needed weights, to discuss in the interdisciplinary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 136	Continued From page 2	4 136		

team (IDT) meetings, and to notify the physician and Registered Dietician (RD) of significant weight loss or gain.

Review of a document provided by the facility titled, "New Nutrition Assessment/MDS (Minimum Data Set) Note" dated 03/31/21 documented R17 weighed 157.7 pounds on 03/23/21.

Review of a document provided by the facility titled "Weight History," dated 05/02/21 indicated R17 weighed 156.5 pounds.

Review of R17 significant change "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/19/21, revealed the resident had a "Brief Interview for Mental Status (BIMS)," score of two out of 15, indicating severe cognitive impairment. The assessment revealed the resident was independent with eating with set up from staff. The assessment revealed the resident weighed 157 pounds and the resident's height was five feet, six inches. The assessment indicated the Care Area Assessment (CAA) triggered under nutrition and directed the staff to develop a care plan.

Review of a care plan provided by the facility, dated 05/26/21 indicated R17 was nutritionally at risk and the resident was on a mechanically altered diet. The care plan indicated staff were to notify the physician and RD of significant weight loss or gain for R17.

Review of a document provided by the facility titled "IDT (Interdisciplinary Team) Meeting Notes," dated 06/02/21 indicated R17's weight remained stable over a 30-day period. The document indicated the resident was on a regular/chopped diet, received Ensure Plus three

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 136	Continued From page 3 times a day, was eating approximately 50 percent of his meals, and was consuming 100 percent of his nutritional supplements. The document indicated R17 voiced he had a poor appetite since his stroke. Review of a document provided by the facility titled "Weight History," dated 06/02/21 showed R17 weighed 153.2 pounds, indicating a 2.85 percent loss since 03/23/21. Review of documents provided by the facility titled "Nurse Note," for the months of July 2021 and August 2021 failed to address changes in R17's weight. Review of a document provided by the facility titled "Weight History," dated 07/09/21 showed R17 weighed 150.6 pounds, indicating a 4.5 percent loss since 03/23/21. Review of a document provided by the facility titled "Weight Chart," dated 08/08/21 indicated R17 sustained significant weight loss of 13.8 pounds from the last recorded weight of 150.6 pounds. The resident's current weight of 136.8 pounds indicated a 9.16 percent loss since 07/09/21. The document revealed a Registered Nurse (RN) was notified of the weight loss of over three percent. There was no indication of what steps were taken by the RN after the electronic notification alert was made in the medical record. There was no evidence to show R17 was re-weighed or that weekly weights were implemented by nursing. Review of an updated care plan provided by the facility, dated 08/23/21 indicated R17 was nutritionally at risk. The care plan did not address that R17 sustained a significant weight loss. The	4 136		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 136	Continued From page 4	4 136		

care plan indicated the staff were to encourage the resident to eat during mealtimes, provide nutritional supplements and snacks as ordered, and to notify the physician and RD of a significant weight loss or gain.

Review of a document provided by the facility titled "IDT Quarterly Screen," dated 08/26/21 indicated a chart review was conducted and R17 continued to require setup assistance for self-feeding. The form failed to address R17's significant weight loss as identified on the 08/08/21 "Weight Chart."

Review of a document provided by the facility titled, "Nurse Note" dated 08/26/21 documented R17 was started on antibiotics for a Urinary Tract Infection.

A document provided by the facility titled "Nutrition Assessment," dated 09/16/21, was completed by RD9. The form documented R17's last weight was on 08/08/21 with a result of 136.8 pounds. The note continued and indicated if that weight was accurate, R17 sustained a significant weight loss of 12.6 percent. This would indicate a total loss of 20.9 pounds over the past six months, or a 13.3 percent overall change in the resident's weight. The note indicated the resident required 1550 to 1870 kilocalorie (kcal; 1 kilocalorie equals 1000 calories) per day. RD9 wrote R17 received Ensure Plus three times a day which provided the resident 350 kcal and 13 grams of protein each (Three Ensure Plus supplements would provide a total of 1050 kcal per day). RD9 documented the resident consumed 20 percent of his meals and approximately 75 percent of supplements. RD9 recommended the resident remained on a regular chopped diet with texture as tolerated, and to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING: _____ B. WING _____	11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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4 136	Continued From page 5	4 136		

continue to offer him Ensure Plus three times a day. There was no evidence the resident's physician was notified of the significant weight loss at this time.

Review of a document provided by the facility titled "Weight History," dated 09/19/21 showed R17 weighed 127.2 pounds, indicating a 19.34 percent loss since 03/23/21.

The document provided by the facility titled "IDT Meeting Notes," was signed by the physician on 09/21/21, indicating he was made aware of R17's significant weight loss 44 days after it was identified. The form documented R17 weighed 136.8 pounds on 08/08/21 and his body mass index (BMI) was 22.1, which fell within acceptable range for his age. The IDT notes continued, and indicated if the 08/08/21 weight was accurate, the resident lost 13.8 pounds over one month which was a 9.2 percent weight loss and would be considered a significant weight loss. The form lacked evidence that new orders were received from the physician at that time.

Review of a document provided by the facility titled "Weight History," dated 09/27/21 showed R17 weighed 128.2 pounds, indicating an 18.71 percent loss since 03/23/21.

Review of a document provided by the facility titled "Nurse Note," dated 09/29/21, revealed staff notified R17's physician was of the resident's decreased appetite and received new orders to increase the resident's Remeron (an appetite stimulant/mood stabilizer) to 15 milligrams (mg) to be administered daily at bedtime.

Review of a document provided by the facility titled "Weekly Skin/Weight Condition Review,"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING: _____ B. WING _____	11/03/2021

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4 136	Continued From page 6 dated 10/01/21, indicated R17 sustained a significant weight change, received a regular chopped meal, was noted to be refuse more meals, and received Ensure Plus three times per week, as well as Magic Cup twice a day at 2:00 PM and 8:00 PM. Review of a document provided by the facility titled "Weight History," dated 10/03/21 showed R17 weighed 125.9 pounds, indicating a 20.16 percent loss since 03/23/21. Review of a document provided by the facility titled "Weekly Skin/Weight Condition Review," dated 10/08/21, showed R17's was 124.8 pounds, indicating a 20.86 percent loss since 03/23/21. RD9 documented food preferences were discussed with R17, and she updated his menu. The document revealed R17's received Ensure Plus with meals and snacks, totaling six times daily. The recommendations were to continue weekly weights. Review of a document provided by the facility titled "Weight History," dated 10/17/21 showed R17 weighed 128.6 pounds, indicating an 18.45 percent loss since 03/23/21. Review of a document provided by the facility titled "Nutrition Assessment," dated 10/19/21 indicated R17's last weight was 128.9 pounds as of 10/17/21, and he had a BMI of 20.8, which fell below the resident's optimal range for his age. The entry revealed R17 had a noted decline in intake noted over the past three months. The document revealed R17's Ensure Plus was increased from three times daily to six times a day on 10/06/21 due to continued weight loss with consistent supplement intake. The form documented R17 had a weight loss of one	4 136		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 136	Continued From page 7	4 136		

percent over the last 30 days, 16.4 percent over the last three months, and 20.1 percent over the past six months.

Review of an updated care plan provided by the facility, dated 10/21/21 indicated R17 was nutritionally at risk and had sustained a significant weight loss.

Review of a document provided by the facility titled "Weekly Skin/Weight Condition Review," dated 10/21/21 indicted R17's current weight was 128.6 pounds. The document indicated R17 consumed more supplements than actual food. The document revealed the resident's physician was notified and the current treatments for the resident were to provide Ensure Plus six times a day. RD9 indicated she met with R17 and addressed food preferences and updated the menu.

During an observation on 10/26/21 at 12:07 PM, staff delivered R17's meal tray which included a bottle of Ensure Plus. The staff member set up R17's meal, opened the bottle of Ensure Plus and, handed it to the resident. R17 was observed to drink the Ensure Plus. R17 was served a regular chopped meal, he was able to feed himself, and consumed approximately 90 percent of the meal during this observation.

During an interview on 10/26/21 at 1:36 PM, RD9 stated R17's appetite was not good, and he had been eating less. RD9 stated R17 received supplements which were increased from three times a day to six. RD9 stated R17 had an increase in Remeron, and she had addressed the resident's food preferences following the noted weight loss. RD9 stated she kept track of residents' weights on a monthly basis and if a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING: _____ B. WING _____	11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILO MEDICAL CENTER	1190 WAIANUENUE AVENUE HILO, HI 96720

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4 136	Continued From page 8	4 136		

resident was identified with a significant weight loss, they were added to a weekly meeting for review. The meeting included the Director of Nursing (DON), RAI Coordinator, and the Assistant Administrator.

During an interview on 10/27/21 at 9:39 AM Certified Nursing Assistant (CNA) 8 stated the staff could see a resident's weight change in the medical record and if there was a weight loss staff were to notify the nurse.

During an interview on 10/27/21 at 9:36 AM, Registered Nurse (RN) 11 stated the CNAs were to inform the nurses if there was a weight loss for a resident. The nurse then needed to determine if there was a discrepancy. If there was a question about a discrepancy, the resident would be re-weighed. Nursing should notify the physician and the RD immediately if a weight loss was identified so they could investigate causes and develop interventions.

During an interview on 10/27/21 at 10:05 AM, RD9 stated R17 should have been re-weighed by nursing after 08/08/21 since the resident sustained over a three percent weight loss.

During an interview on 10/27/21 at 11:59 AM, RD10 confirmed he was the supervisor of RD9. He stated he reviewed RD9's documentation and confirmed RD9 did not address R17's weigh loss until 09/24/21.

During an interview on 10/28/21 at 9:04 AM, RD9 and RD10 were both present. RD9 stated she would review residents' weights monthly to identify significant weight changes. RD9 stated if a resident sustained a significant weight loss, staff were to implement weekly weights so the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING: _____ B. WING _____	11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 136	Continued From page 9	4 136		

resident could be monitored more closely. RD9 stated nursing was to re-weigh the resident if the resident had a three percent or more weight loss to ensure accuracy. RD9 stated R17 had consistent weights until 08/08/21 and staff did not re-weigh or implement weekly weights per the facility's protocol. RD9 stated she was on leave multiple times during August 2021. RD10 stated RD9 missed a QAPI meeting while on leave, which was normally the process used for notifying the physician of a weight change. RD10 further stated typically another RD from the hospital side would step in and address the basic needs of a resident when the assigned RD was not available. RD10 stated since they were in a rural area, RD positions were short. During this interview, both RD9 and RD10 reported they were unable to locate documentation to show the physician was notified of the significant weight change when identified. RD9 stated she increased R17's nutritional supplement on 10/06/21 to address the resident's significant weight loss.

During an interview on 10/28/21 at 12:22 PM, the Regional Nursing Director stated she reviewed the clinical records for R17 and confirmed the resident sustained a significant weight loss. The Regional Nursing Director stated her expectation was for nursing to re-weigh the resident if a three percent or greater weight loss was noted. The Regional Nursing Director stated if the resident was recognized as having a weight loss or gain staff were to implement weekly weights. The Regional Nursing Director stated she was aware, the clinical record lacked evidence that interventions were implemented when R17's weight loss was identified. She reported her expectations would be for the RD to be involved and review the services being provided to the resident on a weekly basis. The Regional Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING: _____ B. WING _____	11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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4 136	Continued From page 10 Director confirmed there was a lapse before anything was done for R17 after the significant weight loss. During an interview on 10/28/21 at 1:07 PM, the Medical Director stated he believed he became aware of R17's weight loss approximately two months ago (September 2021). The Medical Director stated a nurse manager informed him of the weight loss of R17. Once he was made aware, he ordered blood work and a CT (Computed Tomography) scan of the resident's brain. The Medical Director stated the dietary supplements were not really effective and the decline in R17's weight was possibly related to his dementia diagnosis. The Medical Director stated the facility attempted to find an etiology and measures to increase the resident's caloric intake to possibly reverse the weight loss. Review of a document provided by the facility titled "LTC (Long-Term Care) Skin & Weight Meeting," dated October 2021, indicated the purpose was ". . .To evaluate residents with significant weight changes. . .and to ensure timely intervention by the facility Interdisciplinary Team. . .Skin & Weight meeting will be conducted by the facility on a weekly basis. . .Residents who demonstrate a significant change in condition, significant weight loss/gain or gradual, consistent weight loss will be placed on weekly weights until stability is demonstrated and maintained for at least four weeks. Review of such residents will be documented using the Skin/Weight Condition Review form and placed in the LTC Skin and Weight note in the EMR (electronic medical record). The nursing staff will ensure the attending physician and/or ANP (Advance Nurse Practitioner) is informed of the skin/weight change. . .The Skin/Weight Condition Review	4 136		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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4 136	Continued From page 11	4 136		

placed in the resident's records will serve as documentation of each resident reviewed. Physician's orders will be required for new interventions deemed necessary by the Skin and Weight Committee. . ."

2) Review of a document provided by the facility titled "Patient Registration Form," indicated R20 was admitted to the facility on 05/20/21.

Review of R20's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 08/18/21, revealed the resident had a "Brief Interview for Mental Status (BIMS)," score of 15 out of 15 which indicated the resident was cognitively intact.

Review of a document provided by the facility titled "Consultation Record," dated 06/28/21 indicated R20 informed the eye doctor that he was near sighted (cannot see long distances).

Review of a document provided by the facility titled "Nurse Note," dated 06/28/21 indicated R20 had an eye exam scheduled and prescription glasses had been ordered.

Review of a document provided by the facility titled "Nurse Note," dated 08/12/21 indicated the nurse faxed R20's eye prescription to a national vision center.

Review of a document provided by the facility titled "Nurse Note," dated 08/12/21 indicated a nurse received a return call from the national vision center. The nurse was informed that they did not take R20's insurance. The entry revealed the nurse then faxed over the resident's eyeglass prescription to a local vision center on 08/12/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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4 136	Continued From page 12 Review of a document provided by the facility titled "Nurse Note," dated 08/25/21 indicated facility staff called the local vision center to find out the status of R20's prescription glasses. The note indicated the eye center was closed and staff would attempt the next day. Review of a document provided by the facility titled "Social Services Note," dated 10/19/21 indicated R20 wanted an update on the status of his prescription eyeglasses. It was documented the Social Worker followed up with nursing and was informed national vision center would not fill his eyeglass prescription due to not accepting R20's insurance. The entry revealed the Social Worker called the local vision center and was informed they did not receive a fax regarding R20's prescription for glasses on 08/12/21. During an interview on 10/25/21 at 11:11 AM, R20 stated he had an eye exam a few months ago and still had not received his prescription eyeglasses. The resident stated he was near sighted. During an interview on 10/26/21 at 3:13 PM, the Social Worker stated the problem began with the initial eye exam. The doctor who conducted the eye exam did not fill eyeglass prescriptions. The Social Worker stated R20 had to wait a long time before the doctor's office let the facility know the doctor did not fill eyeglasses. The Social Worker confirmed it was not until 08/12/21 that the eye prescription was sent to the national vision center. The Social Worker also confirmed the national vision center did not participate in R20's insurance plan and the eye prescription was then sent to a local vision center. The Social Worker stated there was a COVID outbreak on 09/04/21 and local vision center was closed. The Social	4 136		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING: _____ B. WING _____	11/03/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 136	Continued From page 13 Worker stated the facility did not have a specific policy for vision or for obtaining prescription eyeglasses. During an interview on 10/28/21 at 12:26 PM, the Regional Nursing Director stated her expectation was to follow up on the needs of the resident. 3) The facility's Restorative/Splinting Policy was requested by the survey team, however no policy related to restorative care/splinting was provided to the team prior to survey exit. During an interview conducted with the Administrator on 10/28/21 at approximately 9:56 AM, she stated the facility did not have a policy addressing restorative care/splinting. Review of R23's undated "Patient Registration Form," provided directly to the survey team, revealed R23 was admitted to the facility on 08/20/20, with diagnoses which included history of stroke and hemiplegia (paralysis of one side of the body). Review of R23's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 08/21/21, indicated a Brief Interview for Mental Status (BIMS) score of eight, indicating moderate cognitive impairment. The MDS indicated R23 had Range of Motion (ROM) impairment to her upper and lower extremities on both sides of her body, and that a splint or brace had not been applied to the resident on any of the seven days prior to the ARD. Review of R23's "General Care Plan," dated 09/13/21 and provided directly to the survey team, indicated staff was to apply a resting hand splint the resident's right upper extremity and conduct a skin assessment with the application of	4 136		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING: _____ B. WING _____	11/03/2021

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4 136	Continued From page 14 the splint every day. The splint was to remain in place from 10:00 AM until 2:00 PM daily. Review of R23's facility provided "Orders: Item Detail Report," dated 09/09/20 through current, indicated an order for a resting hand splint to be placed on the resident's right upper extremity for up to four hours per day as tolerated. Review of R23's "Occupational Therapy (OT) Note", dated 09/22/20 and provided directly to the survey team, read, "Spoke with [Nurse] regarding adherence to the splinting schedule. Per discussion, resident tolerating 4 hours per day without problems with skin integrity. Nursing staff with no concerns at this time;" and "Nursing to continue with resting hand splint to RUE [right upper extremity], 4 hrs [hours] daily." Observation on 10/25/21 at 1:33 PM revealed R23 was lying in her bed. The resident's right arm and hand were contracted. R23 was not observed to be wearing a brace or splint of any kind. A splinting device was observed to be hanging on the device which mounted the television to the resident's bed. Observation on 10/26/21 at 11:22 AM revealed R23 was lying in her bed watching television. The resident was not wearing a splint or brace to her right upper extremity. A splint continued to hang on the resident's television mounting device next to her bed. Observation on 10/26/21 at 1:30 PM revealed R23 was lying in her bed. The resident was not wearing a splint or brace. A splint continued to hang on the television mounting device next to the resident's bed.	4 136		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 136	Continued From page 15 During an observation and interview with the Social Worker (SW) on 10/26/21 at 3:45 PM, the surveyor and the SW observed R23 together. R23 was lying in her bed watching television and was not wearing a splint on her upper right extremity. When R23 was asked, by the SW, where her splint was, the resident pointed to the splint hanging on the television mounting device next to her bed. When asked, by the surveyor, if she would wear the brace if it was applied to her right upper extremity, R23 nodded yes. When the resident was asked, by the surveyor, if staff applied the splint to her upper extremity every day, R23 said, "Not always." R23 confirmed the splint had not been applied on that day or the day before. During an interview with the Administrator on 10/28/21 at 9:56 AM, she stated, "If [a splint] was ordered and on the plan of care, staff should be putting it [the splint] on per the order and/or the plan of care." During an interview with Certified Nursing Assistant (CNA) 8 on 10/28/21 at 10:10 AM, she indicated the resident's splint was to be applied every day from 10:00 AM until 2:00 PM. She indicated she applied the resident's splint every time she worked with the resident; however, she was unsure if other staff were doing the same. During an interview with the Regional Nursing Director on 10/28/21 at 12:32 PM, she stated it was her expectation splints would be applied according to a resident's physician's orders and their plan of care. She indicated any refusals to wear a splint by a resident should be documented in the resident's clinical record.	4 136		